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No. 10-

In The Supreme Court of The United States

SOJOURN CARE, INC.,
D/B/A SOJOURN CARE OF TULSA,
Petitioner,

v.

KATHLEEN SEBELIUS,
SECRETARY OF THE UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Did the Tenth Circuit Court of Appeals err when it dismissed Petitioner's appeal of the district court's remand order for lack of appellate jurisdiction under 28 U.S.C. § 1291 (final judgment)?

2. Did the Tenth Circuit Court of Appeals err in failing to grant mandamus relief under 28 U.S.C. § 1651 to prevent the district court's delegation of essential judicial functions (determination of Article III standing) to the self-interested Article II agency?

PARTIES TO THE PROCEEDINGS

Pursuant to Rule 14.1(b), Petitioner Sojourn Care, Inc. advises the Court that all of the parties to this proceeding are identified on the caption.

CORPORATE DISCLOSURE STATEMENT

Sojourn Care, Inc. has no parent corporation, and no publicly-held company owns 10% or more of its stock.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Sojourn Care, Inc. respectfully petitions for a writ of certiorari to review a judgment of the United States Court of Appeals for the Tenth Circuit.

OPINIONS BELOW

In re Sojourn Care, Inc., Provider Reimbursement Review Board (H.H.S.), Case No. 07-1272 (unreported) (May 16, 2007) (granting expedited judicial review on timely appeal of hospice cap repayment demand) (Appendix ("A.") 28-30).

Sojourn Care, Inc. d/b/a Sojourn Care of Tulsa v. Leavitt (H.H.S.), 4:07 cv 375 (N.D. Ok.) (Feb. 13. 2008) (unreported) (hearing transcript, excerpt; granting summary judgment of invalidity of hospice cap regulation) (A. 16-27).

Sojourn Care, Inc. d/b/a Sojourn Care of Tulsa v. Leavitt (H.H.S.), 4:07 cv 375 (N.D. Ok.) (Mar. 3, 2009) (unreported) (order remanding case to HHS for determination of extent of Article III injury to plaintiff-hospice; refusing relief) (A. 5-15).

Sojourn Care, Inc. d/b/a Sojourn Care of Tulsa v. Sebelius (H.H.S.), 09-5031 and 09-5066 (Jun. 30, 2010) (unreported) (order dismissing appeal and cross-appeal for lack of appellate jurisdiction and denying writ of mandamus) (A 1-4).

Sojourn Care, Inc. d/b/a Sojourn Care of Tulsa v. Sebelius (H.H.S.), 09-5031 and 09-5066 (Aug. 20, 2010) (unreported) (denying both rehearing and rehearing en banc) (A. 31-32).

STATEMENT OF JURISDICTION

The Tenth Circuit entered an order dismissing the appeals of both Petitioner and Respondent for lack of jurisdiction (rehearing denied 8/20/10). This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

U.S. Const. art. III, § 2, cl. 1 provides in pertinent part that:

> The judicial power shall extend to all Cases, in Law and Equity, arising under this Constitution, the laws of the United States ... .

42 U.S.C. § 1395f(i)(2) (the hospice reimbursement cap) provides, in pertinent part:

> (A) The amount of payment made under this part for hospice care provided by (or under arrangements made by) a hospice program for an accounting year may not exceed the "cap amount" for the year (computed under subparagraph (B)) multiplied by

the number of medicare beneficiaries in the hospice program in that year (determined under subparagraph (C)).

* * * *

(C) For the purposes of subparagraph (A), the "number of Medicare beneficiaries" in a hospice program in an accounting year is equal to the number of individuals who have made an election under subsection (d) of this section with respect to the hospice program and have been provided hospice care by (or under arrangements made by) the hospice program under this part in the accounting year, such number reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year or under a plan of care established by another hospice program.

42 C.F.R. § 418.309(b) (HHS' implementation of 42 U.S.C. § 1395f(i)(2)) provides:

Each hospice's cap amount is calculated by the intermediary by multiplying the adjusted cap amount determined in paragraph (a) of this section by the number of Medicare beneficiaries who elected to receive hospice care from that hospice during the cap period. For

purposes of this calculation, the number of Medicare beneficiaries includes –

(1) Those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap and who have filed an election to receive hospice care, in accordance with § 418.24 from the hospice during the period beginning on September 28 (35 days before the beginning of the cap period) and ending on September 27 (35 days before the end of the cap period).

(2) In the case in which a beneficiary has elected to receive care from more than one hospice, each hospice includes in its number of Medicare beneficiaries only that fraction which represent the portion of a patient's total stay in all hospices that was spent in that hospice... .

42 U.S.C. § 1395oo(f)(1) provides, in pertinent part:

Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following

sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received.

28 U.S.C. § 1291 provides, in pertinent part:

The courts of appeal (other than the United States Court of Appeals for the Federal Circuit) shall have jurisdiction of appeals from all final decisions of the district courts of the United States... .

28 U.S.C. § 1651(a)(1) provides that:

The Supreme Court and all courts established by Act of Congress may issue all writs necessary or appropriate in aid of their respective jurisdictions and agreeable to the usages and principles of law.

Pertinent excerpts of the above-referenced provisions are appended hereto.

STATEMENT OF THE CASE

I. STATEMENT OF FACTS

Sojourn Care is a Medicare-certified hospice provider located in Oklahoma. Petitioner provides hospice care to eligible terminally-ill Medicare patients and services to their families. The Federal

government pays hospice providers like Sojourn Care pursuant to a Medicare program established under Title XVIII of the Social Security Act (the "Medicare Act"). The United States Department of Health and Human Services ("HHS") administers the hospice benefit and reimburses hospice providers on a per-diem basis for services to its beneficiaries.

However, aggregate annual Medicare payments to hospice providers are subject to an aggregate annual provider cap (the "cap"). Any provider whose revenues from Medicare exceed its aggregate cap allowances for any given year are subject to retrospective demands by HHS for repayment of the difference. 42 U.S.C. § 1395f(i)(2).

The hospice cap is calculated as the product of the "number of Medicare beneficiaries" on service in a given year and a per-patient allowance (adjusted annually for inflation). 42 U.S.C. § 1395f(i)(2)(A). Because beneficiaries may be on hospice service in more than one fiscal year, the Medicare Act mandates that the "number of Medicare beneficiaries" is to be "reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year." 42 U.S.C. § 1395f(i)(2)(C).

In promulgating a regulation to implement this cap calculation, HHS both acknowledged the statutory mandate to make a proportional allocation of each patient's cap allowance and also candidly

admitted that it was not going to follow such mandate:

> Although section 1814(i)(2)(C) of the Act specifies that the cap amount is to be adjusted "to reflect the proportion of the hospice care that each such individual was provided in a previous or subsequent accounting year . . ." such an adjustment would be difficult in that the proportion of the hospice stay occurring in any given year would not be known until the patient dies or exhausted his or her hospice benefits. We believe the proposed **alternative** of counting the beneficiary in the reporting period where the beneficiary used most of the days of covered hospice care will achieve the intent of the statute without being burdensome.

48 F.R. 38,146 at 38,158 (Aug. 22, 1983) (emphasis added).

In its final regulation implementing the hospice cap, HHS did not establish the proportional allocation method expressly required by Congress — instead, HHS merely allocated the entirety of each patient's cap allowance **only** to the initial year of service. 42 C.F.R. § 418.309(b)(1). The problem with this "alternative" calculation of the "number of Medicare beneficiaries" is that it results in the assignment of the entire cap allowance to the first

reporting period even if most of the hospice care for that patient is rendered in a subsequent period. Thus, unused cap amounts in the earlier fiscal year are "trapped" in the earlier year, regardless of whether the beneficiary continues to receive care in subsequent years. This leads to understated cap allowances and overstated cap repayment demands.

For fiscal years 2003 and 2004, Sojourn Care's revenues were below the cap allowances by approximately $2.2 million, cumulatively. Sojourn Care did not receive any cap repayment demands for these years, but such surpluses may not be carried forward to later years. However, for fiscal year 2005, Sojourn Care's revenues exceeded the cap allowance (as calculated under 42 C.F.R. § 418.309(b)(1)) by more than $2 million, resulting in HHS issuing to Sojourn Care a repayment demand in that sum.

II. PROCEDURAL HISTORY

Sojourn Care timely appealed the fiscal year 2005 cap repayment demand to HHS' appellate body, the Provider Reimbursement Review Board ("PRRB"). Sojourn Care's appeal to PRRB asserted that the regulation used to calculate the demand, 42 C.F.R. § 418.309(b)(1), was contrary to statute and that the demand issued under such regulation should be set aside. The PRRB, without objection from HHS, found that there was more than $10,000 in dispute, held that it lacked authority to consider the challenge to the validity of the regulation, and

granted to Sojourn Care the right to seek expedited judicial review. (A. 28-30.)

On July 2, 2007, Sojourn Care timely filed suit challenging the validity of the hospice cap regulation, 42 C.F.R. § 418.309(b)(1), and the repayment demand issued there under. The district court had jurisdiction under the Medicare Act, 42 U.S.C. § 1395oo(f)(1). The Medicare Act instructs reviewing courts to apply the Administrative Procedure Act. 42 U.S.C. § 1395oo(f)(1). The Administrative Procedure Act ("APA") requires courts to "hold unlawful and set aside" improper agency action. 5 U.S.C. § 706(2).

The parties brought cross-motions for summary judgment. For its part, HHS asserted that Sojourn Care "lacked standing" to challenge the regulation absent proof that Sojourn Care's hospice cap liability would be reduced under a hypothetical, alternative regulation which followed the statutory mandate by proportionally allocating each patient's cap allowance.

On February 13, 2008, after considering extensive oral argument regarding Sojourn Care's standing, the district court found Sojourn Care had sufficient standing and held the regulation invalid, criticizing the regulation as follows:

> ... it doesn't honor the statutory language that the number must be reduced to reflect the proportion of hospice care that each such individual

> was provided ... The number of beneficiaries is simply not reduced under this regulation in any way to reflect the proportion of care that each such individual was provided in a previous or subsequent reporting year ... I simply don't believe that it follows the statutory mandate in the statute.

(A. 24-25.) The district court did not issue a written opinion on summary judgment.

After considering cross-motions for entry of judgment, on March 3, 2009, the district court entered an order. (A. 5-15.) In this order, the district court did not hold the regulation unlawful and set the regulation (and repayment demand issued there under) aside, as required by the APA, 5 U.S.C. § 706(2). (*Id.*) The district court noted its prior finding that the regulation was invalid, but found "Article III standing ... problematic" because Sojourn Care declined to offer a hypothetical cap calculation showing potential cap liability under an alternative, non-existent regulation. (*Id.*)

As a result, the district court remanded to HHS for a determination of whether Sojourn Care had suffered Article III injury. (*Id.*) Specifically, the district court ordered HHS to determine "whether the proportional application of the cap amount between fiscal years in which the hospice stay occurred, as set out in 42 U.S.C. § 1395f(i)(2)(C), reduces the excess claimed by HHS for fiscal year

2005, and, if so, by what amount." (*Id.*) The district court held that, as a result of its doubts regarding the precise extent of Article III injury, "plaintiff is not entitled to judgment or injunctive relief." (*Id.*) The district court then closed the case. (*Id.*)

Both parties appealed the March 3, 2009 order and briefed the case to the Tenth Circuit.

On June 30, 2010, the Tenth Circuit issued an order finding the district court's remand order non-final, refusing mandamus relief, and dismissing both appeals. (A. 1-4.) The Tenth Circuit characterized the district court's order as giving Petitioner "a declaratory judgment" but "deferr[ing] decision on certain form of relief ... until after a remand to the ... PRRB for additional proceedings." (A. 2.) The Tenth Circuit also denied mandamus relief, finding that the district court's decision was "not clearly and indisputably wrong, as it must be to warrant the issuance of a writ." (A. 3.) On August 20, 2010, the Tenth Circuit denied Petitioner's request for a rehearing. (A. 31-32.) This petition timely follows.

Since the district court issued its March 3, 2009 judgment, more than ten Federal district courts have: (a) found that plaintiff-hospices subject to repayment demands calculated under 42 C.F.R. § 418.309(b)(1) have standing to challengethe regulation; (b) declared the regulation unlawful as contrary to express Congressional mandate; and (c) set aside as invalid cap repayment demands

issued under the regulation.[1] No court has upheld the regulation.

REASONS FOR GRANTING THE WRIT

Having found the hospice cap regulation invalid, the district court should have discharged its duty under the APA to "hold unlawful and set aside" the challenged agency regulation and repayment demand. 5 U.S.C. § 706(2). Instead, the district court abdicated an essential judicial function by remanding the case to HHS for an inappropriate and hypothetical determination of Sojourn Care's Article III injury. Under Rule 10, the district court's action, and Tenth Circuit's failure to intervene, presents a radical and dangerous departure "from the accepted and usual course of judicial proceedings" so as to warrant "an exercise of this Court's supervisory powers."

Whether by review of the district court order as a final judgment or through its mandamus powers, the Tenth Circuit should have taken up this issue and prevented the delegation of essential

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[1] *See, e.g., Los Angeles Haven Hospice, Inc. v. Leavitt*, 2009 WL 5868513 (C.D. Cal. Jul. 13, 2009); *Lion Health Servs., Inc. v. Sebelius*, 689 F.Supp.2d 849, 855 (N.D. Tex. 2010); *Hospice of N.M., LLC v. Sebelius*, 691 F.Supp.2d 1275, 1295 (D.N.M. 2010); *Tri-County Hospice, Inc. v. Sebelius*, 2010 WL 784836 (E.D. Ok. Mar. 8, 2010); *IHG Healthcare v. Sebelius*, 2010 WL 2380743 (S.D. Tex. Jun. 13, 2010); *Russell-Murray Hospice, Inc. v. Sebelius*, 2010 WL 2814411 (D.D.C. Jul. 20, 2010).

judicial functions for Article III standing determinations to an interested Articl II agency.

III. THE REMAND ORDER SHOULD HAVE BEEN REVIEWED AND REVERSED

A. If The District Court Issued A Partial Declaratory Judgment, Then Such Judgment Is Final And Appealable

The Tenth Circuit characterized the district court's March 3, 2009 determination as a partial "declaratory judgment." (A. 2.) Arguably, there is no language in the district court's order which can be construed as giving Sojourn Care a partial declaratory judgment. (A. 5-15.) If the district court's order does include such a partial declaratory judgment, there is little question that the entire judgment would be final and subject to appeal. *Compare Shalala v. Schaefer*, 509 U.S. 292 (1993) (noting, in the analogous Social Security context, that where a partial declaratory judgment is given with remand, such decision is a final, appealable judgment).

B. Even If The District Court's Order Is Deemed "Not Final," The Tenth Circuit Should Have Exercised Mandamus Powers

In *La Buy v. Howes Leather Co.*, 352 U.S. 249 (1957), this Court affirmed a writ of mandamus precluding non-consensual referral of a matter to a special master for trial. The Court noted that

"abdication of the judicial function" is a primary ground for mandamus relief. *La Buy*, *supra*, 352 U.S. at 256. In the present case, the district court abdicated an essential judicial function (determination of Article III standing) in a manner more egregious than that found acceptable in *La Buy*. The district court's referral of the Article III injury question to the interested Article II agency is not only an improper delegation of an essential judicial function, but also a plain violation of due process.

Essential judicial functions may not be delegated by Article III courts to Article I or II adjudicative bodies. *Crowell v. Benson*, 285 U.S. 22, 57-58 (1932) (essential attributes of judicial power must remain with Article III courts); *and Northern Pipeline Constr. Co. v. Marathon Pipe Line Co.*, 458 U.S. 50, 81 (1982) (judiciary designed to "stand independent of the Executive and Legislature – to maintain the checks and balances of the constitutional structure, and also to guarantee that the process of adjudication itself remained impartial"; holding Bankruptcy Act of 1978 invalid for vesting "essential attributes of the judicial power" outside of Article III courts).

Essential judicial functions include conducting jury trials, issuing writs, the power to execute upon judgment, certain sentencing-related functions, and even considering testimony. *Northern Pipeline Co.*, *supra*, 458 U.S. at 85-86 (enumerating essential functions improperly delegated under the

Bankruptcy Act); *U.S. v. Stephens*, 424 F.3d 876, 881 (9th Cir. 2005) (judicial determination of substance abuse testing non-delegable); *U.S. v. Elsoffer*, 644 F.2d 357, 359 (5th Cir. 1981) (per curiam) (court must consider actual testimony on suppression, not merely review findings).

Similarly, determination of Article III standing is an essential judicial function which may not be delegated. *See* U.S. CONST. Art. III, § 2, cl. 1 (defining the scope of federal judicial power, requiring "case" or "controversy"); *Crowell, supra*, 285 U.S. at 57-58 (upholding Magistrate Act, in part on basis that jurisdictional facts were to be decided *de novo* by the reviewing federal court).

Yet, the district court ordered remand to HHS and/or the agency's appellate division, the PRRB,[2] as follows:

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[2] To the extent the district court's order purports to remand the matter to the HHS's adjudicative body, the PRRB, such a direct remand is also improper. *See Anaheim Memorial Hospital v. Shalala*, 130 F.3d 845, 851 (9th Cir. 1997) (there is "no such thing as remand to the PRRB," *citing Assoc. of American Med. Colleges v. Califano*, 569 F.2d 101, 109 (D.C. Cir. 1977) (final determination is prerequisite to PRRB action)). As held by the PRRB itself, to "fashion a new methodology of apportionment" (which would be necessary to perform the hypothetical calculation ordered by the district court here) is "beyond the scope of the Board's authority;" and "requiring the Board to approve a method would usurp the authority of the Secretary." *Heart to Heart Hospice*, PRRB Case Nos. 07-1993 and 09-0980 (Mar. 8, 2010).

> The court believes the proper course of action at this stage is to remand the case to HHS for further proceedings to determine whether, and to what extent, plaintiff has been injured by application of the regulation at issue.
>
> * * * *
>
> This case is remanded to the PRRB for determination of whether the proportional allocation of the cap amount between fiscal years in which the hospice stay occurred, as set out in 42 U.S.C. § 1395f(i)(2)(C), reduces the excess claimed by HHS for fiscal year 2005 and, if so, by what amount.

(A. 14.) The Supreme Court noted that a long-recognized purpose of the All Writs Act is to prevent "usurpation of the judicial power." *Id.* at 257. *See also Prudential Ins. Co. of America v. U.S. Gypsum*, 991 F.2d 1080 (3d Cir. 1993) (using mandamus to vacate appointment of law school dean to determine pre-trial matters).[3] Indeed, the mandamus power has also been used to set aside improper agency remands. *See New York, Susquehanna & W.R. Co. v. Follmer*, 254 F.2d 510

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[3] Mandamus is applied sparingly because of the inefficiency and disruptive effect of piecemeal appeals. *Prudential Ins. Co., supra*, 991 F.2d at 1082. But, in the present case, mandamus threatens no disruption because the district court closed the case and both sides have appealed.

(3d Cir. 1958) (applying *La Buy* to set aside an agency remand for a function "well within the ordinary province of a judge").

The district court's judgment not only delegates an essential judicial function, it also confers on an adverse party, in this case an Article II agency, the right to make critical judicial decisions regarding Sojourn Care's claims. Allowing HHS, a party-litigant with a clear stake in the matter, to determine its opponent's Article III injury violates Sojourn Care's procedural due process rights.

In establishing a violation of procedural due process, positive proof of the partiality of the judge/decision-maker is not even a requirement; instead, even the appearance of partiality can lead to a due process violation. *See Liljeberg v. Health Services Acquisition Corp.*, 486 U.S. 847, 859-61 (1988) (what matters is not the reality of bias or prejudice but its appearance); 28 U.S.C. § 455(a) (requiring disqualification of federal judges "in any proceeding in which his impartiality might reasonably be questioned"); FED. R. CIV. P. 53(a)(2) (special master must not have relationship to parties unless the parties consent to appointment of interested master); *Offutt v. U.S.*, 348 U.S. 11, 14 (1954) ("justice must satisfy the appearance of justice"); *and Northern Pipeline, supra*, 458 U.S. at 58 (Federal Judiciary "designed ... to guarantee that the process of adjudication itself remained impartial").

Here, the conflict is clear and undisputed: the district court remanded critical questions to HHS, a party-litigant adverse to Sojourn Care. *See Lacsina Pangilinan v. Holder*, 568 F.2d 708 (9th Cir. 2009) (reversing district court for delegating duty to develop the immigration case to counsel for the government). Allowing an interested and partial agency to make critical determinations regarding Sojourn Care's standing violates Sojourn Care's due process rights[4] and constitutes further support for Sojourn Care's claim on this petition that the action of the district court, and of the Tenth Circuit in refusing to intervene, has "so far departed from the accepted and usual course of judicial proceedings ... as to call for an exercise of this Court's supervisory power." Rule 10.

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[4] To the extent that the district court intended for return of the case once again for further review after hypothetical recalculations, such an instruction also runs afoul of this Court's recent instruction not to turn Administrative Procedure Act review into a game of ping-pong. See *Morgan Stanley Cap. Group, Inc. v. Pub. Util. Dist. 1 of Snohomish Cty.*, 128 S.Ct. 2733, 2745 (2008). And, it is also inconsistent with Congress' intent, in establishing expedited judicial review, to end irrelevant administrative review. Compare *Tallahassee Mem. Regional Med. v. Bowen*, 815 F.2d 1435, 1460 (11th Cir. 1987) (reviewing legislative history of expedited judicial review amendments in detail, noting Congress' frustration with "time consuming and irrelevant administrative review").

1. As A Party Subject To Direct Action Under The Hospice Cap Regulation, Sojourn Care Has Ample Standing

The district court's findings questioning Sojourn Care's standing are themselves in irreconcilable conflict with precedent of this Court. In *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561-562 (1991) the Court noted that where the party in suit is the "object of the action" there is "ordinarily little question that the action ... has caused him injury, and that a judgment preventing or requiring the action will redress it." Here, there should be "little question" that Sojourn Care has standing to challenge the regulation because Sojourn Care is subject to a multi-million dollar cap repayment demand calculated under the regulation. *See id.* See *also Fund for Animals, Inc. v. Norton*, 322 F.3d 728, 733-34 (D.C. Cir. 2003) (observing that a party's standing to seek review of administrative action is typically "self-evident" when the party is the object of the action); *cf. Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 38 (1976) (the purpose of the Article III standing requirement is to ensure that a litigant has a sufficient personal stake in the outcome of the controversy); *Russell-Murray Hospice, Inc. v. Sebelius* 2010 WL 2814411 at *8 (D.D.C.) (holding, in a similar hospice cap case challenging the validity of 42 C.F.R. § 418.309(b)(1), that the "injury in fact in this context [] is the fact that HHS is operating an invalid regulation, leading to accounting and payment inaccuracies"); *Los Angeles Haven Hospice, Inc. v. Leavitt*, 2009 WL

5868513 at *3 (C.D. Cal.) (similar hospice cap case, rejecting assertion that hospices must prove that they would be "better off" under an alternative regulation in order to establish Article III standing to challenge 42 C.F.R. § 418.309(b)(1)); *Lion Health Services, Inc. v. Sebelius*, 689 F.Supp.2d 849, 855 (N.D. Tex. 2010) (similar hospice cap case, injury in fact is use of unlawful calculation method; no need to show "better off" under some alternative calculation); *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265, 280-281 n. 14 (1978) (rejecting argument that standing depended upon whether medical school applicant could show that he would have been admitted but for the challenged affirmative action program); *Larson v. Valente*, 456 U.S. 228, 243, n. 15 (1982) (a plaintiff "need not show that a favorable decision will relieve his every injury," calling such a requirement "draconic"); *and Village of Arlington Heights v. Metropolitan Housing Dev. Corp.*, 429 U.S. 252, 261-262 (1977) (holding that standing existed even though there was no guarantee that plaintiff would successfully obtain its goal if the requested relief were granted).

Because Sojourn Care is directly subject to the challenged regulation, in the form of a multi-million dollar repayment demand calculated under the regulation, Sojourn Care has ample standing to challenge 42 C.F.R. § 418.309(b)(1).

2. Having Found The Regulation Invalid, The District Court Should Have Held It And The Related Repayment Demand Unlawful And Set Them Aside

The instructions of the Administrative Procedure Act, made applicable to this case by 42 U.S.C. § 1395oo(f)(1), are clear: when a court identifies improper agency action, it must hold such action (i.e., the regulation and demand there under) unlawful and set it aside. 5 U.S.C. § 706(2); *and Harmon v. Thornburgh*, 878 F.2d 484 (D.C. Cir. 1989) (when a regulation is found invalid, regulation is to be set aside; parties and court cannot write new regulation; agency must set up new regulation in the first instance). In this case, this Court should instruct the Tenth Circuit to issue a mandamus order vacating the remand order of the district court and entering judgment that holds the regulation and related demand unlawful and sets them aside, as required by the APA.

CONCLUSION

The action of the district court, and subsequent inaction of the Tenth Circuit, threaten to impair the integrity of the judicial branch by permitting a grossly improper delegation of an essential function: the determination of Article III standing. The Tenth Circuit should either have reviewed and reversed the district court's order as a final decision or should have exercised its mandamus power to preclude the unlawful

delegation. Absent intervention, Sojourn Care will face the absurdity of having its Article III standing determined not by an Article III court but rather by the interested and adverse Article II agency. The lower courts need supervision and clear guidance on the proper division of labor and the proper administration of justice in Administrative Procedure Act cases.

Respectfully submitted,

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[DATE STAMP] FILED
United States Court of Appeals
Tenth Circuit
June 30, 2010
Elisabeth A. Shumaker
Clerk of the Court

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT

SOJOURN CARE, INC., d/b/a Sojourn Care of Tulsa, a Delaware corporation,

Plaintiff-Appellant/
Cross-Appellee,

v.

KATHLEEN SEBELIUS, Secretary of the United States Department of Health and Human Services,

Defendant-Appellee/
Cross-Appellant.

09-5031, 09-5066
(D.C. No. 4:07-CV-00375-GFK-PJC)
(N.D. Okla.)

ORDER*

Before **HARTZ**, **GORSUCH**, and **HOLMES**, Circuit Judges.

These appeals are dismissed for lack of appellate jurisdiction. Sojourn Care Inc.'s complaint contains a single cause of action. It contends that a regulation used to calculate certain reimbursements to hospice providers such as itself (42 C.F.R. § 418.309) is contrary to Title XVIII of the Social Security Act (42 U.S.C. § 1395f(i)). So far, the district court has awarded Sojourn a declaratory judgment but deferred decision on certain other forms of relief requested by Sojourn until after a remand to the Provider Reimbursement Review Board (PRRB), for additional proceedings, can be completed. In these circumstances we lack a final judgment that might afford us appellate jurisdiction under 28 U.S.C. § 1291. *See Liberty Mut. Ins. Co. v. Wetzel*, 424 U.S. 737, 743-44 (1976). Neither, in these circumstances, is there a proper basis for the government's cross-appeal. The government, like Sojourn, will have an avenue for obtaining judicial review of any adverse decision by the district court when the case reaches a final judgment. *See Bender v. Clark*, 744 F.2d 1424, 1428 (10th Cir. 1984).

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* This order is not binding precedent except under the doctrines of law of the case, res judicata, and collateral estoppel. It may be cited, however, for its persuasive value consistent with Fed. R. App. P. 32.1 and 10th Cir. R. 32.1.

If we lack appellate jurisdiction to hear Sojourn's appeal under § 1291, Sojourn contends we should still issue a writ of mandamus. *See* 28 U.S.C. § 1651(a). But a writ of mandamus is a "drastic remedy" that may be "invoked only in extraordinary situations." *Barclaysamerican Corp. v. Kane*, 746 F.2d 653, 654 (10th Cir. 1984) (quotation marks omitted). This is not such a case. Sojourn can obtain meaningful review of the district court's rulings in the normal course, when proceedings finish. *See In re: Cooper Tire & Rubber Co.*, 568 F.3d 1180, 1187 (10th Cir. 2009) ("[T]he party seeking issuance of the writ must have no other adequate means to attain the relief he desires" (quotation marks omitted)). And whether or not the district court is in error, a question we do not decide, its decision is not clearly and indisputably wrong, as it must be to warrant the issuance of a writ. *See id.* (writ of mandamus may issue only when right to it is "clear and indisputable" (internal quotation marks omitted)).**

These appeals are **DISMISSED**.

** Sojourn has not sought to invoke our jurisdiction under 28 U.S.C. § 1292(a)(1), and it is our general practice to avoid passing on possible arguments in support of our jurisdiction that the parties themselves haven't raised and had the opportunity to join issue on. *Cf. Kaw Nation ex rel. McCauley v. Lujan*, 378 F.3d 1139, 1142 (10th Cir. 2004) ("[W]e need not consider a new argument in support of jurisdiction" not raised in a party's opening brief). We see no reason to depart from that practice in this case.

Entered for the Court,

/s

ELISABETH A. SHUMAKER, Clerk

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OKLAHOMA

SOJOURN CARE, INC.,

Plaintiff,

vs. No. 07-CV-375-GKE-PJC

MICHAEL O. LEAVITT, Secretary of the Department of Health and Human Services,

Defendant.

ORDER

This matter comes before the court on plaintiff's Motion for Entry of Proposed Form of Judgment (Doc. No. 45), defendant's Motion for Entry of Remand Order (Doc. No. 44), and plaintiff's Motion for Judicial Notice (Doc. No. 46). For the reasons set forth below, plaintiff's Motion for Entry of Proposed Form of Judgment is denied, defendant's Motion for Remand is sustained, and plaintiff's Motion for Judicial Notice is denied as moot without prejudice to refile should the case return to federal court.

Procedural History

Plaintiff, Sojourn Care, Inc., is a Medicare certified hospice provider in Tulsa, Oklahoma. Pursuant to a program established under Title XVIII of the Social Security Act (the "Medicare Act"), plaintiff receives reimbursement for hospice care provided to Medicare beneficiaries. To be eligible for hospice benefits, an individual must be "terminally ill," which is defined as "a medical prognosis that the individual's life expectancy is 6 months or less." 42 U.S.C. §1395x(dd)(3)(A). A patient who elects to receive hospice benefits waives all rights to Medicare payments for treatment of the underlying terminal illness and related conditions by someone other than the individual's attending physician or the chosen hospice provider. 42 U.S.C. §1395d(d)(2)(A). A beneficiary may elect hospice care for an unlimited number of benefit periods, provided each election is accompanied by the requisite certification of terminal illness. 42 U.S.C. §1395d(d)(1). However, the total payment to a hospice in an accounting year is limited by a statutory "cap," and payments in excess of the statutory cap must be refunded by the hospice provider. 42 U.S.C. §1395f(i)(2)(A) The statutory cap is calculated for each hospice care provider by multiplying the applicable "cap amount" by the "number of Medicare beneficiaries" in the hospice program that year. *Id.* The "number of beneficiaries" is to be calculated, according to the statute, as follows:

> For the purposes of subparagraph (A), the "number of medicare beneficiaries" in a hospice program in an accounting year is equal to the number of individuals who have made an election under subsection (d) of this section with respect to the hospice program and have been provided hospice care by (or under arrangements made by) the hospice program under this part in the accounting year, *such number reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year* or under a plan of care established by another hospice program.

42 U.S.C. §1395f(i)(2)(C) (emphasis added). While the statute refers to proportioning payment between accounting years, the regulation implementing the hospice cap provides:

> Each hospice's cap amount is calculated by the intermediary by multiplying the adjusted cap amount determined in paragraph (a) of this section by the number of Medicare beneficiaries who elected to receive hospice care from that hospice during the cap period. For purposes of this calculation, the number of Medicare beneficiaries includes --
>
> > *(1) Those Medicare beneficiaries who have not*

> *previously been included in the calculation of any hospice cap and who have filed an election to receive hospice care, in accordance with §418.24 from the hospice during the period beginning on September 28 (35 days before the beginning of the cap period) and ending on September 27 (35 days before the end of the cap period).*

42 C.F.R. §418.309 (emphasis added). Thus, under the regulation, a patient who first sought "number of beneficiaries" in that year, while a patient who first entered hospice care on September 28, 2005, would be counted in the 2006 fiscal year.

The cap amount for the year ending October 31, 2005, was $19,778 per person. Plaintiff, for that time period, received an average of $23,663 per person. On December 15, 2006, Medicare sent plaintiff a demand for repayment of $2,078,074 for exceeding its fiscal year 2005 cap. On March 12, 2007, plaintiff filed an appeal of the cap determination with Medicare's Provider Reimbursement Review Board ("PRRB"), challenging the validity of 42 C.F.R. §418.309(b). The PRRB found it was without the authority to decide the legal question of whether the regulation was valid, and,

pursuant to 42 U.S.C. §139500(0(1), granted plaintiff's request for expedited judicial review. Thereafter, plaintiff filed this action.

Plaintiff's Complaint of Declaratory and Injunctive Relief and for Sums Due Under the Medicare Act (Doc. No. 2) sought declaratory judgment that the regulation under which HHS determined the cap, 42 C.F.R. §418.309(b) is invalid; declaratory judgment that HHS's prior calculation of Sojourn Care's cap liability for fiscal year 2005 is invalid; an order requiring HHS to return to plaintiff with interest all monies it has paid towards repayment of the alleged 2005 overpayment; and a preliminary injunction enjoining HHS from continuing to demand repayment of the alleged 2005 overpayment and from calculating subsequent fiscal year alleged overpayments.

Plaintiff filed a motion for summary judgment on the declaratory judgment claims (Doc. No. 11) and defendant filed a cross motion for summary judgment on all claims of plaintiff (Doc. No. 19). Ruling from the bench on February 19, 2008, the court denied defendant's motion for summary judgment and granted plaintiff's motion for summary judgment, finding 42 C.F.R. §418.309(b) invalid as contrary to the plain language of 42 U.S.C. §1395(i)(2)(C). The court's ruling was limited to validity of the regulation. The court made no finding as to whether plaintiff had actually been harmed by the application of the regulation or, if so, in what amount.

Subsequently, plaintiff filed its Motion for Entry of Proposed Form of Judgment in which it sought not only judgment setting aside as unlawful the regulation and HHS's prior calculation of plaintiff's fiscal year 2005 hospice cap liability, but also an order enjoining HHS "from prospective use of this portion of the regulation in calculating the hospice cap liability of any hospice provider under 42 U.S.C. §1395(0(i)(2)," and an award of costs and attorneys fees. (Doc. No. 45). HHS, in turn, seeks remand to HHS "for proceedings not inconsistent with the Court's February 13, 2008 Opinion from the Bench." (Doc. No. 44).

The issue posed by the competing motions is whether plaintiff is entitled to any additional relief at this point and, if so, the appropriate relief. Resolution of this issue, in turn, depends largely on whether plaintiff has established injury sufficient to confer standing and empower the court to act.

Standing

Because the Medicare Act incorporates the Administrative Procedures Act, plaintiff must meet both the constitutional requirements subsumed by the Article III "case or controversy" limitation on judicial power and the judicially created prudential requirements under the APA. *See Western Shoshone Business Council v. Babbitt*, 1 F.3d 1052, 1055 (10th Cir. 1993). The court addresses first the requirements for APA standing.

Under §702 of the APA, "[a] person suffering legal wrong because of an agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof." Thus, a plaintiff claiming a right to sue under the APA must identify some "agency action" that affects him and show the agency action has caused him to suffer "legal wrong" or that he is "adversely affected or aggrieved" by that action. *Western Shoshone Business Council*, 1 F.3d at 1055, citing *Lujan v. National Wildlife Fedn.*, 497 U.S. 871, 883 (1990) ["*Lujan I*"]. Adverse effect or agrievement has been interpreted as requiring a plaintiff to show that "the interest sought to be protected...is arguably within the zone of interests to be protected or regulated by the statute or constitutional guarantee in question." *Western Shoshone Business Council, supra, citing Association of Data Processing Serv. Orgs., Inc. V. Camp*, 397 U.S. 150, 153 (1970). Plaintiff clearly satisfies the requirements for standing under the APA. It alleged HHS's enforcement of 42 C.F.R. §418.309(b) has imposed on it an obligation to reimburse amounts in excess of the cap.

Article III standing, however, is more problematic. Article III of the Constitution restricts federal courts to the adjudication of "cases or controversies." U.S. Const. Art III, §2, cl. I. "The standing inquiry ensures that a plaintiff has a sufficient personal stake in a dispute to ensure the existence of a live case or controversy which renders judicial resolution appropriate." *Tandy v. City of*

Wichita, 380 F.3d 1277, 1283 (10th Cir. 2004). To establish Article III standing, a plaintiff must allege that 1) he or she has suffered an "injury in fact" that is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical; 2) the injury is fairly traceable to the challenged action of the defendant; and 3) it is likely, as opposed to merely speculative, that the injury will be redressed by the relief requested. *Id.* at 1283, citing *Lujan V. Defenders of Wildlife*, 504 U.S. 555, 560-561 (1992) ["*Lujan II*"] The party seeking to invoke federal jurisdiction bears the burden of establishing all three elements of standing. *Lujan II* at 561.

Since the elements of Article 111 standing are not mere pleading requirements, but "an indispensable part of the plaintiff's case," each element must be supported in the same way as any other matter on which the plaintiff bears the burden of proof, *i.e.*, with the manner and degree of evidence required at the successive stages of the litigation. *Id.* Thus, at the pleading stage, general factual allegations of injury resulting from the defendant's conduct may suffice, because the court presumes that general allegations embrace those specific facts that are necessary to support the claim." *Id.* In response to a summary judgment motion, the plaintiff can no longer rest on "mere allegations," but must set forth by affidavit or other evidence "specific facts" which for purposes of the summary judgment motion will be taken as true. *Id.* And at the final stage, those facts (if controverted) must be

"supported adequately by the evidence adduced at trial." *Id.*

In its summary judgment motion, plaintiff presented the declaration of its chief executive officer, David Daucher, who stated:

> For fiscal year 2005 (ended October 31, 2005), Sojourn Care served many patients first admitted in fiscal year 2004 and a few patients first admitted in fiscal year 2003. Medicare paid Sojourn Care for these services as rendered in fiscal year 2005. However, because of the cap regulations which traps [sic] cap room in prior years, Sojourn Care received no cap allocation for these patients in fiscal year 2005.

(Doc. No. 11, Daucher Declaration, ¶6). Plaintiff also submitted correspondence between the parties and its cost report for fiscal year 2005. (*Id.*, Daucher Declaration. Exs. 13 and C).

Defendant contended in summary judgment proceedings the harm to plaintiff was caused not by application of 42. C.F.R. §418.209(b). but by the fact that the cap was based on an average hospice stay of 70 days, whereas the actual average stay at plaintiff's facility in 2005 was 131 days. Counsel for plaintiff conceded the increase in average length of hospice stays likely accounts for most of the cap excess, but argued application of the challenged

regulation was causing at least part of the overrun. [Tr. of Proceedings, February 13, 2008, pp. 49-50].

While plaintiff presented adequate proof to withstand defendant's summary judgment motion, the court made clear at the hearing that more evidence of harm would be required for plaintiff to obtain injunctive relief. Plaintiff has come forward with no evidence whatever. Therefore, plaintiff is not entitled to judgment or injunctive relief. The court believes the proper course of action at this stage is to remand the case to HHS for further proceedings to determine whether, and to what extent, plaintiff has been injured by application of the regulation at issue.

Plaintiff's Motion for Proposed Form of Judgment (Doc. No. 45) is denied and defendant's Motion for Entry of Remand Order (Doc. No. 44) is sustained. This case is remanded to the PRRB for determination of whether the proportional application of the cap amount between fiscal years in which the hospice stay occurred, as set out in 42 U.S.C. §1395f(i)(2)(C), reduces the excess claimed by HHS for fiscal year 2005 and, if so, by what amount. Plaintiff's Motion for Judicial Notice (Doc. No. 46), which pertains to docket sheets of other cases involving similar challenges to the regulation at issue, is denied as moot without prejudice to refile at a later date.

ENTERED this 3rd day of March, 2009.

/s

GREGORY K. PRIZZELL
United States District Judge
Northern District of Oklahoma

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF OKLAHOMA

SOJOURN CARE, INC., d/b/a SOJOURN CARE OF TULSA, a Delaware Corporation,

Plaintiff,

V. No. 07-CV-375-GKF-PJC

MICHAEL O. LEAVITT, Secretary of United States Department of Health and Human Services,

Defendant.

REPORTER'S TRANSCRIPT OF PROCEEDINGS

HAD ON FEBRUARY 13, 2008

MOTION HEARING

BEFORE THE HONORABLE GREGORY K. FRIZZELL, Judge

APPEARANCES:

For the Plaintiff:

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For the Defendant:

Mr. Daniel E. Bensing
U.S. Department of Justice,
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PROCEEDINGS

February 13, 2008

THE COURT: Be seated please.

THE CLERK: We're here in the matter Sojourn Care, Inc. vs. Michael Leavitt, case number 07-CV-375-GKF. Will the parties please enter their appearance.

MS. SCOGGINS: Linda Scoggins and Brian Daucher for the plaintiff.

THE COURT: And last name, I'm sorry.

MS. SCOGGINS: Brian Daucher. We had just filed an application for admission pro hac vice.

THE COURT: Which we granted this morning.

MS. SCOGGINS: Okay.

THE COURT: D-O-W-S-H-I-R-E?

MS. SCOGGINS: D-A-U-C-H-E-R.

THE COURT: D-A-U-C-H-E-R?

MS. SCOGGINS: Yes.

THE COURT: All right.

MR. BENSING: Daniel Bensing with the Civil Division of the Justice Department on behalf of the defendant. Ms. Cathy McClanahan is with me as well, but she's not counsel.

THE COURT: Welcome all. I apologize for being late. Today is Rotary and they had the meeting in a different location with a parking garage that took a long time to discharge cars, so we ran over here as quickly as we could, and I apologize.

I'm particularly interested in -- and you-all have not ever appeared before me, I enjoy oral argument and it is not infrequent to change my mind going into one of these matters but I'm particularly interested in standing, in injury in fact, particularly because I see, you know, the 2.1 whatever, million payment that had to be paid over a five-year period and now we're looking at another one, and I'm really wrestling with standing. So just to alert you, you need to address that. But lawyers changed my mind at oral argument yesterday, so it's not impossible. This is defendant's motion for summary, unless you-all think that I ought to address one of the other motions first. It would seem to me the motions summary ought to be addressed first addressed, but perhaps you have agreed otherwise.

MS. SCOGGINS: Well actually, Your Honor, I believe we filed the motion for summary judgment first, the plaintiffs did.

THE COURT: All right.

MR. BENSING: And we cross moved, and so in any order that the Court wants.

THE COURT: All right, very well. But you-all agree that the motions for summary ought to be addressed first, I guess that was

MS. SCOGGINS: Yes, absolutely.

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It is, I think, very instructive, and I will tell the Court this. Reference was made to the letter for the plaintiff's 2006 cap year. That, in fact, went out yesterday, February 12. I e-mailed a copy to plaintiff's counsel last night. It seeks reimbursement for approximately $4.2 million. So we see over the 2002 to 2006 time period plaintiffs are bumping up against the cap and now substantially exceeding it. And again, the only conclusion I think you can draw is that their length of stay is the cause of it and the congressional mandate for a cap is what is causing them the harm. They haven't shown that the rule is, in any sense is the problem.

THE COURT: Well, it certainly seems that that probably is the majority of their travail at this point in time, but do they not have standing if part of their problem relates to the regulations. And I understand, I would have been much happier if I had had something concrete to tell me this is what we calculate the harm we've suffered to have been. But if I am to -- and I'm going to ask them more about that but let's say I accept their argument, is it not enough for standing that part of their problem and not all of it relates to the regulation?

MR. BENSING: I certainly concede that, yes. The other point in terms of looking back --

THE COURT: I mean, it does seem to me that to a certain extent they are seeking any port in a storm here, and this is an available port particularly

if the port will enjoin your attempts to seek reimbursement.

MR. BENSING: Yes, sir.

THE COURT: I mean that would be a great port. Go ahead.

MR. BENSING: But, yes, if they can show that then they would have standing to challenge the rule to the extent that the rule is causing them some harm. That's the evidentiary showing they simply have not made.

The other thing is the plaintiffs have -- maybe it's just language shorthand but they refer to capping trapped in the past and they want to move it forward. The regulation and the statute doesn't contemplate a carryforward right.

THE COURT: Like income averaging.

MR. BENSING: Like income average. In the plaintiff's theory we would have to do a proportional allocation on a patient-by-patient basis and that might -- might move some of the cap forward into another year. But they can't just say, oh, I've got a million nine in unused cap in '03 --

THE COURT: I'm going to apply it to 05.

MR. BENSING: Yeah.

THE COURT: See, that's -- you heard my question to Ms. Scoggins. I can't imagine that it would have much effect on '05. Agreed -

MR. BENSING: Agreed. So that's, I think, what I want

***

regulation does, and for that reason we believe that the regulation is invalid.

THE COURT: How do you-all wish to address this, Mr. Bensing, because you have cross motion. Was your argument relative to both? I wasn't entirely clear.

MR. BENSING: No, our briefs are identical, Your Honor, and I think that we have said everything we need to say on both motions.

THE COURT: All right. With due respect, and frankly the trigger has to be pulled here one way or the other, not intending to create great problems here, but with due respect I agree with the plaintiffs here that the regulation as written does not comport or comply with the statute, and I don't believe the delay bars a finding of invalidity here. As reflected on this record, the change in the program apparently has changed the economic model such that the application of this regulation now is such that it has drawn this attack don't believe that the statutory language which requires that the number of Medicare beneficiaries is to be reduced is in any way reflected in an allocation to one of the fiscal years, one or the other, and it's certainly not -- it doesn't honor the statutory language that the number must be reduced to reflect the proportion of hospice care that each such individual was provided. The government understandably in its advocacy focuses upon the words "to reflect the proportion." But the question, even when we're focusing on that clause is one which I don't believe passes scrutiny here. The

number of Medicare beneficiaries is simply not reduced under this regulation in any way to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year, and focusing on this last phrase, "that each such individual was provided in a previous or subsequent accounting year," rather the regulation for administrative convenience, and I make no moral determination here. Obviously it was adopted for administrative convenience which I have recognized on this record is a common practice. I simply don't believe that it follows the statutory mandate in the statute.

Now I don't believe, frankly, that summary judgment should extend beyond a finding of invalidity. So if I'm reading the motions correctly, the motion for summary judgment of the plaintiff is granted, the motion for summary judgment of the defendant is denied. And also with respect to standing which gave me great pause here, I do believe, although I don't believe at all that the ultimate accounting here is going to save the plaintiff's bacon, it's going to have a very small impact, I believe. You know, I reserve judgment on that. In fact, I don't believe I should be the one to render judgment on that. Frankly, I'll take your suggestions here, but it seems to me this matter ought to be sent back to PRRB for that determination. I can always retain some jurisdiction for any matters that they can't address, but that's not before me today. I'll let you think about how you want to do that.

Now, in terms of the application for stay pending adjudication of dispositive motions. Well, the dispositive motions have been adjudicated so in that sense it's moot. That's docket number 29. Docket number 32, the unopposed motion for hearing on plaintiff's application for stay is moot because I just ruled on it. So I think we've handled everything on my plate today. I can let you think about how we wish to proceed. As I say, you know, in the event the plaintiff wishes to seek an injunction from this Court -- and let's just call it what it is, it's an injunction, it's not a motion to stay -- the plaintiff is going to have to come up with a lot better evidence. I mean because the plaintiff here, as I understand the request to stay pending adjudication of dispositive motions, was to stop any and all collections. Well, it appears on this record presented on the motion for summary adjudication that it may affect pennies on the dollar, but the bulk of that overpayment obligation is going to remain. So you-all need to get your army of accountants on this thing before you come back to me. Anything else?

MR. BENSING: Is there going to be a written order, Your Honor?

THE COURT: Well, let me give you the reality here. When I came on just a year ago I was handed about 325 motion many of very, very old, years old, and so that's in part why we have hearings like this because I can do it much more efficiently on the record. Unfortunately it doesn't -- it's not perfect but for administrative convenience in order to provide

some justice for some other folks this is how it's going to be done. So the record will reflect the ruling of the Court. We will simply issue a very short order, written order granting the motion for summary judgment for the plaintiff, denying that of the defendant. The docket sheet will reflect the adjudication of the other two motions. Anything else?

MS. SCOGGINS: I believe that's all, Your Honor.

THE COURT: I would like to get to the point where I could render these scholarly decisions but, you know, tomorrow we've got a motion, real old, and then we've got a Paxil case on Friday and then next Tuesday we've got a two-week hearing on whether or not chicken waste, the application of chicken litter should be enjoined in a million acre parcel straddling Oklahoma and Arkansas, so we've got our hands full.

All right, thank you-all very much. We are adjourned.

A TRUE AND CORRECT TRANSCRIPT.

CERTIFIED: /s/

Glen R. Dorrough
United States Court Reporter

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670
Phone: 410-786-2671 FAX: 410-786-5298

Suzanne Cochran, Esq. Chairperson
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, CPA
Anjali Mulchandani-West
Yvette C. Hayes

Refer to: 07-1272 MAY 16, 2007

CERTIFIED MAIL

James C. Pyles, Esq.
Powers, Pyles, Sutter & Verville, PC
1501 M Street N. W.
Washington. D.C. 20005-1700

RE: Sojourn Care of Tulsa
Provider No. 37-1707
FYE 10/31/05
PRR Case No. 07-1272

Dear Mr. Pyles:

This is in response to the Provider's April 20, 2007 request that the Provider Reimbursement Review Board (Board) determine whether expedited judicial review is appropriate for the hospice cap issue. Pursuant to 42 U.S.C. § 1395oo(f)(1), the Board can determine that it is without the authority to decide

the question of whether the regulation, 42 C.F.R. § 418.309, is valid.

The Board has reviewed the submission of the Provider pertaining to the requests for hearing and expedited judicial hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for the appeal exceeds $10,000, as required for an individual appeal. The estimated amount in controversy is subject to recalculation by the Intermediary for the actual final amount.

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Provider is entitled to a hearing before the Board;

2) based upon the Provider's assertions regarding the hospice cap issue, there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) it is without the authority to decide the legal question of whether the regulation, 42 C.F.R § 418.309(b), is valid.

Accordingly, the Board finds that the hospice cap issue properly falls within the provisions of 42 U.S.C. § 1395oo (f)(1) and hereby grants the Provider's request for expedited judicial review for the issue. The Provider has 60 days from the receipt

of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Attachments Containing Patient Information

The Board is returning material from the initial hearing request and EJR request that contain patient information. The Board's instructions require that this information be redacted to protect patient confidentiality. See, Board's Instructions at http:/www cms hhs gov/PRRBReview/02 PRRB Instructions.asp.

Board Members Participating

Suzanne Cochran, Esq.
Gary B. Blodgett, DDS
Elaine C. Powell, CPA
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

/s

Suzanne Cochran, Esq.
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1), Patient Identifying material

cc: Ken Godbold, Palmetto GBA
Wilson Leong, BCBSA

[DATE STAMP] FILED
United States Court of Appeals
Tenth Circuit
August 20, 2010
Elisabeth A. Shumaker
Clerk of the Court

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT

SOJOURN CARE, INC., d/b/a Sojourn Care of Tulsa, a Delaware corporation,

Plaintiff-Appellant-Cross/Appellee,

v.

KATHLEEN SEBELIUS, Secretary of the United States Department of Health and Human Services,

Defendant-Appellee-Cross/Appellant.

Nos. 09-5031 and 09-5066

ORDER

Before **HARTZ, GORSUCH**, and **HOLMES**, Circuit Judges.

Appellant/Cross-Appellee's petition for rehearing is denied.

The petition for rehearing en banc was transmitted to all of the judges of the court who are in regular active service. As no member of the panel and no judge in regular active service on the court requested that the court be polled, that petition is also denied.

Entered for the Court,

/s

ELISABETH A. SHUMAKER, Clerk

Article. III.

Section. 2. The judicial Power shall extend to all Cases, in Law and Equity, arising under this Constitution, the Laws of the United States, and Treaties made, or which shall be made, under their Authority; -- to all Cases affecting Ambassadors, other public Ministers and Consuls; -- to all Cases of admiralty and maritime Jurisdiction; -- to Controversies to which the United States shall be a Party; -- to Controversies between two or more States; -- [between a State and Citizens of another state;--][8] between Citizens of different States, -- between Citizens of the same State claiming Lands under Grants of different States, [and between a State, or the Citizens thereof, and foreign States, Citizens or Subjects.][9]

In all Cases affecting Ambassadors, other public Ministers and Consuls, and those in which a State shall be Party, the supreme Court shall have original Jurisdiction. In all the other Cases before mentioned, the supreme Court shall have appellate Jurisdiction, both as to Law and Fact, with such Exceptions, and under such Regulations as the Congress shall make.

The Trial of all Crimes, except in Cases of Impeachment; shall be by Jury; and such Trial shall be held in the State where the said Crimes shall

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[8] Changed by the Eleventh Amendment.

[9] Changed by the Eleventh Amendment.

have been committed; but when not committed within any State, the Trial shall be at such Place or Places as the Congress may by Law have directed.

28 U.S.C. § 1291. Final decisions of district courts

The courts of appeals (other than the United States Court of Appeals for the Federal Circuit) shall have jurisdiction of appeals from all final decisions of the district courts of the United States, the United States District Court for the District of the Canal Zone, the District Court of Guam, and the District Court of the Virgin Islands, except where a direct review may be had in the Supreme Court. The jurisdiction of the United States Court of Appeals for the Federal Circuit shall be limited to the jurisdiction described in sections 1291(c) and (d) and 1295 of this title.

28 U.S.C. § 1651. Writs

(a) The Supreme Court and all courts established by Act of Congress may issue all writs necessary or appropriate in aid of their respective jurisdictions and agreeable to the usages and principles of law.

(b) An alternative writ or rule nisi may be issued by a justice or judge of a court which has jurisdiction.

(2)(A) The amount of payment made under this part for hospice care provided by (or under arrangements made by) a hospice program for an accounting year may not exceed the "cap amount" for the year (computed under subparagraph (B)) multiplied by the number of medicare beneficiaries in the hospice program in that year (determined under subparagraph (C)).

(B) For purposes of subparagraph (A), the "cap amount" for a year is $6,500, increased or decreased, for accounting years that end after October 1, 1984, by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year.

(C) For purposes of subparagraph (A), the "number of medicare beneficiaries" in a hospice program in an accounting year is equal to the number of individuals who have made an election under subsection (d) of this section with respect to the hospice program and have been provided hospice care by (or under arrangements made by) the hospice program under this part in the accounting year, such number reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting

year or under a plan of care established by another hospice program.

(D) A hospice program shall submit claims for payment for hospice care furnished in an individual's home under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.

42 C.F.R. § 418.309 Hospice cap amount.

The hospice cap amount is calculated using the following procedures:

(a) The cap amount is $6,500 per year and is adjusted for inflation or deflation for cap years that end after October 1, 1984, by using the percentage change in the medical care expenditure category of the Consumer Price Index (CPI) for urban consumers that is published by the Bureau of Labor Statistics. This adjustment is made using the change in the CPI from March 1984 to the fifth month of the cap year. The cap year runs from November 1 of each year until October 31 of the following year.

(b) Each hospice's cap amount is calculated by the intermediary by multiplying the adjusted cap amount determined in paragraph (a) of this section by the number of Medicare beneficiaries who elected to receive hospice care from that hospice during the cap period. For purposes of this calculation, the number of Medicare beneficiaries includes –

(1) Those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap and who have filed an election to receive hospice care, in accordance with § 418.24, from the hospice during the period beginning on September 28 (35 days before the beginning of the cap period) and ending on September 27 (35 days before the end of the cap period).

(2) In the case in which a beneficiary has elected to receive care from more than one hospice, each hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total stay in all hospices that was spent in that hospice. (The hospice can obtain this information by contacting the intermediary.)

48 F.R. 38,146 at 38,158 (Aug. 22, 1983)

e. *Number of Hospice Beneficiaries.* As specified by section 1814(i) of the Act, each individual hospice's cap amount is equal to 40 percent of the regional average amount, adjusted for inflation or deflation (as determined in accordance with subsections b through d above) multiplied by the number of Medicare patients who elected to receive care from the hospice in the reporting year. We estimate that the average cap amount per beneficiary for the first year of the hospice program will be approximate $4232. This estimate was established by strict application of the requirements for determining the cap amount as contained in the legislation. The requirements do not allow discretion in the computation method. We used 1978 data as the basis for this estimate; however, we believe that 1979 data will be available by the time we publish final regulations. If so, we will use those data. The amount of the cap may vary somewhat based on the refinement of the data base that occurs between now and the issuance of final regulations and as a result of using the more recent 1979 data. Based on our experience, however, we do not believe that either of these factors will result in a significant variation in the cap amount per beneficiary, nor do we believe that a significant change in the cap amount could be accomplished without a change in the legislative requirements. (Note: We recognize that the estimated cap amount we have computed is significantly lower than the amount anticipated by the Congress at the time the legislation was passed. While we do not have legal discretion to modify the

amount under current law, we understand that attempts are under way legislatively to modify the law and create a higher cap amount.)

The statute specifies that the number of Medicare patients used in the calculation is to be adjusted to reflect the portion of care provided in a previous or subsequent reporting year or in another hospice. With respect to the adjustment necessary to account for situations in which a beneficiary's election overlaps two accounting periods, we are proposing to count each beneficiary only in the reporting year in which the preponderance of the hospice care would be expected to be furnished rather than attempting to perform a proportional adjustment. Although section 1814(i)(2)(C) of the Act specifies that the cap amount is to be adjusted "to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year * * *", such an adjustment would be difficult in that the proportion of the hospice stay occurring in any given year would not be known until the patient died or exhausted his or her hospice benefits. We believe that the proposed alternative of counting the beneficiary in the reporting period where the beneficiary used most of the days of covered hospice care will achieve the intent of the statute without being burdensome.

42 U.S.C. § 1395oo(f)(1)

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question, of law, or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of

rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located, (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such providers as a group with respect to any matter involving an issue common to such providers.